CURRENT "NON-MEDICAID" SERVICE ACTIVITIES

Please Note
The sequence in which items are presented is not meant to imply a priority order.

For Review and Prioritization

by the

Joint Legislative and Executive Task Force On Mental Health Service Delivery and Financing

"Non-Medicaid" Community Mental Health Services

Activity #1: CRISIS AND COMMITMENT SERVICES

Description: This activity includes costs associated with legal proceedings for anyone who has been recommended for detention and treatment under the state's involuntary commitment laws. Such legal costs are not eligible for Medicaid funding, whether the person is a Medicaid enrollee or not. For persons not enrolled in Medicaid, included in this category are assessments to determine whether the person is a danger to themselves or others due to a mental illness; triage centers; and other crisis response services such as short-term respite beds, hotlines, referral services, and short-term crisis counseling.

FY 03 Persons Served:

2,900	Non-Medicaid Children
18,400	Non-Medicaid Adults
5,000	Medicaid clients involuntarily detained (estimate)
26,300	

FY 03 Non-Medicaid Cost: $28.8 Million

Estimated Impact of Continued Funding

Crisis services are provided 24 hours a day, 7 days a week to anyone experiencing a crisis regardless of Medicaid status. In accordance with state statute and WAC, any individual presenting in crisis is evaluated to determine if he/she meets detention (commitment) criteria, or if he/she would benefit from other less restrictive services. Early crisis intervention and provision of less restrictive services often enables a person to return to a previous level of function that eliminates the need for commitment services.

Triage Centers offer an alternative to hospital emergency rooms, incarceration, and inpatient psychiatric admissions. In those RSNs where triage center services exist, they are available to anyone regardless of medical coverage.

Judicial proceedings for individuals who have been involuntarily detained are provided as required by statute. These laws assure due process for citizens to ensure they are not detained inappropriately or indefinitely. Court activities include providing assigned council, prosecuting attorneys, judges, testimony from county designated mental health professionals and other professionals, and court clerk duties.

Estimated Impact of Reduced or Eliminated Funding

Not funding or reducing crisis services would result in increased police response to persons with mental illness, increased charity costs to local hospitals and emergency departments with resultant increased costs for insured patients, increased utilization of local and state psychiatric hospitals, and general decreased “livability” of our communities.

Not funding judicial proceedings would be in violation of state law. Not funding crisis and commitment services would require statutory change (RCW 71.05, 71.34, and 71.24), as well as amendments to MHD/RSN contract requirements.

"Non-Medicaid" Community Mental Health Services

Activity #2: JAIL SERVICES

Description: This activity includes services such as mental health assessments, interventions, and diversions to more appropriate community placement that are provided by the community mental health system to persons in jail. Such services are not eligible for federal Medicaid funding, even when the person served is a Medicaid enrollee. The costs reported here are only those incurred and reported by the community mental health system, not the much larger amount expended out of county corrections budgets.

FY 03 Persons Served: Statewide data not available.

FY 03 Non-Medicaid Cost: $2.0 Million

Estimated Impact of Continued Funding

For over 10 years, the Legislature and MHD have emphasized the importance of improved collaboration between the public mental health system and local and state criminal justice agencies. Recent legislation including SSB 621, SB 6002, SB 5011, and last session SB 6358, have not only encouraged, but required increased expenditure of public mental health resources to serve these populations. Historically, MHD contracts with RSNs and review activity by the MHD have either required or encouraged these collaborations.

Through these efforts, practice standards have evolved that include identification and engagement activities in jail or prison. Independent studies have demonstrated that these efforts result in decreased criminal recidivism, and in decreased use of inpatient psychiatric hospitalization. Continued funding of these activities will improve public safety, decrease jail and prison crowding, decrease expensive inpatient care, and decrease the burden on the forensic systems at the State Hospitals.

Estimated Impact of Reduced or Eliminated Funding

If no funding for these services is provided, we can predict an increase of police involvement with citizens who have a mental disorder, more mentally ill individuals in jails and prisons, increased utilization of forensic services at the State Hospital, and decreased ability to control forensic commitments to the civil side of the State Hospitals for defendants who are unable to be restored to competency. This ultimately will undermine efforts to decrease civil beds at the State Hospitals, and result in significant erosion of state-only dollars available to the RSN's as these funds will be lost to liquidated damages for individuals placed in civil beds without input from the RSN's.

CDMHP activities in jails and prisons are largely mandated in RCW 71.05 and RCW 10.77. The requirements for CDMHP services have increased through numerous legislative changes since 1996 and continuing through 2004. To effectively offer no state-only public mental health services in jails and prisons would require statutory change to both RCW 10.77 and 71.05.

"Non-Medicaid" Community Mental Health Services

Activity #3: COMMUNITY INPATIENT CARE

Description: Short-term treatment – generally expected to last no longer than 17 days – in community hospitals and free-standing evaluation and treatment ("E&T") facilities for non-Medicaid children and adults who are experiencing an episode of severe psychiatric illness.

Also included here are the costs of outpatient services – such as medication management, case management, counseling, and day treatment – for the non-Medicaid children and adults who were hospitalized one or more times during the course of the year.

This activity grouping also includes approximately $6.9 million that was expended on care for Medicaid enrollees in hospitals and E&T facilities subject to the "IMD exclusion". Because such facilities specialize in the treatment of mental illness and have more than 16 beds, federal Medicaid will not share in the cost for a Medicaid enrollee age 21-64.

FY 03 Persons Served:

69	Non-Medicaid Children
1,850	Non-Medicaid Adults
1,000	Medicaid Adults in IMD facilities (estimate)
2,900	

FY 03 Non-Medicaid Cost: $26.8 Million

Estimated Impact of Continued Funding

Inpatient services are the intensive end of the care continuum. Short-term inpatient services are used to stabilize individuals so they can return to the community, or receive longer-term services at the state hospitals. Individuals who require an inpatient level of care are the most at risk in the system and are most likely to present public safety concerns. Continued funding of these short-term services provides a cost-effective alternative to long-term hospitalizations.

RCW 71.05 requires the RSNs to provide investigations and detentions of individuals who are a danger to themselves or others or are gravely disabled. Funding for these services is necessary for the RSNs to meet the mandates of RCWs 71.05, 71.34, 71.24,10.77 and 70.96(a).

Estimated Impact of Reduced or Eliminated Funding

Without community inpatient placements, all short and long term commitments would occur at the state hospitals. This would require an immediate and substantial increase in capacity at the state hospitals.

There would also be an immediate impact on public safety. Many of the commitments to involuntary inpatient treatment are for individuals who have come into contact with the police and without the hospital alternative they would end up in jail.

Finally, there would be an increased liability on the part of the state and the RSNs for acts that were committed by individuals who were not receiving the appropriate treatment during acute episodes of mental illness.

"Non-Medicaid" Community Mental Health Services

Activity #4: INTENSIVE RESIDENTIAL CARE

Description: This category includes care and treatment in adult residential rehabilitation facilities; in specialized group homes and adult family homes; and in staff-intensive assistance programs for mentally ill adults who live in their own or in shared apartments and houses.

In addition to the cost of care for people not on Medicaid, there are substantial "non-Medicaid" costs for the Medicaid enrollees who live in these settings. These include monitoring and supervision of basic living tasks; rental or food costs in excess of the resident's income; and any mental health treatment and medical care for non-elderly adults who live in facilities that are subject to the IMD exclusion.

Also included here are the cost of outpatient services – such as medication management, case management, counseling, and day treatment – for non-Medicaid adults residing in these programs, and for Medicaid adults living in IMD facilities. For the latter group, $2.0 million of state medical assistance costs ineligible for federal Medicaid match is also included.

FY 03 Persons Served:

13	Medicaid Children
845	Medicaid Adults (428 in IMD's)
54	Non-Medicaid Adults
910	

FY 03 Non-Medicaid Cost: $22.1 Million

Estimated Impact of Continued Funding

Early in the 1980s, the state Mental Health Division asked counties to take action to reduce reliance on state hospitals for hospitalization of involuntarily committed adults. A number of counties developed intensive residential facilities as an alternative to long-term hospitalization. These facilities serve to help transition seriously mentally ill individuals back into community life. Many of these individuals also have serious health problems, chemical dependency, and deficits in basic skills that make it necessary for them to receive intensive monitoring, assistance, and treatment. Continuing to fund these facilities will prevent relapse and the return of many of these individuals to the state hospitals.

Estimated Impact of Reduced or Eliminated Funding

If funding is reduced or eliminated, many or all of these facilities would be forced to close. The state hospitals would lose an important resource for placement, and the length of stay at the state hospitals would increase. Many of the individuals served by these facilities would be unable to manage in other less-intensive residential facilities, boarding homes, or independent housing with community support. An expected outcome would be the long-term rehospitalization of many of these residents. In addition, since there is inadequate affordable available housing in many RSNs, a number of these individuals would become homeless.

"Non-Medicaid" Community Mental Health Services

Activity #5: LESS INTENSIVE RESIDENTIAL CARE

Description: This category includes care, supervision, and assistance in less-specialized and -staffed group care facilities, apartments, and homes. As with the more intensive residential care programs, costs ineligible for Medicaid match include monitoring and supervision of basic living tasks; rental and food costs; and any mental health treatment for non-elderly adults living in facilities co-located with specialized programs subject to the IMD exclusion.

FY 03 Persons Served:

680	Medicaid Adults (49in IMD's)
53	Non-Medicaid Adults
733	

FY 03 Non-Medicaid Cost: $7.0 Million

Estimated Impact of Continued Funding

Less intensive residential facilities, like the intensive residential facilities described above, were developed in the 1980s to help serve individuals being released from state hospitals. Mental health centers made considerable investments, and made long term commitments to meet the needs identified by the state mental health division to provide community residential treatment former state hospital patients. Continuing funding is necessary to allow the development of alternative, affordable housing options, a process that would require a significant amount of capital funds for housing development and several years for development.

Estimated Impact of Reduced or Eliminated Funding

If funding is reduced or eliminated without new funding, and the time necessary for housing development, hundreds of the mentally ill individuals living in these facilities will become homeless. The average individual on Medicaid living in a non-intensive residential facility receives a disability income of $571 per month. In a number of parts of the state, there are almost no rental units available for under $500 per month. There are already too few housing assistance vouchers or low-income housing units available to meet the need, so the result of closing these facilities will be to force many individuals onto the streets.

"Non-Medicaid" Community Mental Health Services

Activity #6: MEDICAID PERSONAL CARE

Description: Hands-on assistance with activities of daily living such as eating, bathing, dressing, and meal preparation. Regional Support Networks pay the state share of this Medicaid benefit for Medicaid enrollees who require such assistance because of their psychiatric, rather than a physical, disability.

FY 03 Persons Served: 250 Medicaid Adults (monthly estimate)

FY 03 Non-Medicaid Cost: $1.5 Million

Estimated Impact of Continued Funding

The state requires RSNs to pay for Medicaid Personal Care (MPC) for individuals who are enrolled in the RSN and whose disability and need for assistance is due to their psychiatric disorder. Individuals who need personal care due to a psychiatric disability are entitled, under law, to the same assistance as individuals who need personal care due to a medical disability. Continued funding is required in order to comply with Medicaid requirements. Providing personal care to individuals also helps prevent hospitalizations or placement in nursing homes.

Estimated Impact of Reduced or Eliminated Funding

Failure to provide funding for this service would result in an increase in hospitalizations and nursing home placement. It would also likely result in legal action against the state.

"Non-Medicaid" Community Mental Health Services

Activity #7: DIRECT CLIENT FINANCIAL ASSISTANCE

Description: This category includes rental assistance for Medicaid and non-Medicaid clients whose incomes are insufficient to afford a safe place to live; "flex funds" to provide short-term emergency assistance such as food, kitchen supplies, and clothes, and payment to providers of services for the purpose of meeting Medicaid spenddown requirements.

FY 03 Persons Served: statewide data not available.

FY 03 Non-Medicaid Cost: $6.5 Million

Estimated Impact of Continued Funding

This category provides a wide range of services which assist individuals to maintain Medicaid health benefits, housing, and basic needs, all of which enable individuals to maintain independent community living. Individuals served with flex funds are primarily multi-system needs children being served by the Interagency Staffing Teams, adults being released from jail and prison, homeless adults, and adults being diverted from emergency rooms and inpatient hospitalization. Continued funding helps prevent homelessness and inpatient hospitalization. Medicaid spenddown funds uses payments to mental health providers to satisfy Medicaid spenddown requirements, thus preserving Medicaid health benefits.

Estimated Impact of Reduced or Eliminated Funding

Failure to provide Medicaid spenddown funding will mean that individuals will be forced to choose between paying for treatment, including necessary medication, or paying for rent, utilities, and food. Many individuals will stop medications and treatment, and end up being hospitalized. If flex funds are not provided, adults leaving prisons or hospitals may not be able to pay for basic needs, leading to a return to crime in order to support themselves, or rehospitalization.

"Non-Medicaid" Community Mental Health Services

Activity #8: HOUSING PROJECTS

Description: This category incorporates a wide variety of projects undertaken by various RSNs to finance housing and treatment facilities, and to arrange safe and affordable housing for mentally ill persons who are homeless or at risk of becoming so. The largest single programs in this category are the Housing Opportunities Fund (HOF) and the Homeless Outreach, Stabilization and Transition Program (HOST) in King County. The HOF provides funds for agencies to build or rehabilitate housing for consumers. The HOST Program continues the work begun by a federal grant to find and engage homeless mentally ill adults, and to link them with needed mental health services and permanent supported housing. Projects such as these are not eligible for federal Medicaid funding, even though most beneficiaries are Medicaid enrollees.

FY 03 Persons Served: statewide data not available.

FY 03 Non-Medicaid Cost: $7.7 Million

Estimated Impact of Continued Funding

There is an acute shortage of affordable housing in the state, and many mentally ill individuals are homeless because of the lack of affordable housing. Continued funding of these programs enables RSNs to build housing capacity targeted to the homeless mentally ill, and to provide the necessary outreach and engagement services to ling individuals to housing and ongoing services.

Estimated Impact of Reduced or Eliminated Funding

Reducing funding will result in more people being left homeless. Homeless mentally ill individuals are more likely to commit crimes and end up incarcerated, and are also high utilizers of psychiatric and medical hospitalization.

"Non-Medicaid" Community Mental Health Services

Activity #9: OUTPATIENT TREATMENT FOR NON-MEDICAID CHILDREN CLASSIFIED AS ACUTELY MENTALLY ILL, OR SEVERELY EMOTIONALLY DISTURBED

Description: Individual and family counseling, case management, day treatment, medication management, consultation to teachers and other care-givers, and related services for non-Medicaid children who are "acutely mentally ill" or "severely emotionally disturbed" according to statutory Priority Population standards; or who are having at least a moderate degree of dysfunction in most social areas or severe impairment of functioning in one area, as measured by an intake score of 50 or lower on the Children's Global Assessment Scale.

See Appendix C for complete state "Priority Population" definitions, and Appendix E for global assessment indicators.

FY 03 Persons Served: 2,500 Non-Medicaid Children

FY 03 Non-Medicaid Cost: $3.2 Million

Estimated Impact of Continued Funding

Outpatient services are the foundation of treatment and stabilization for children's mental health services. Children and youth in this category represent those with the highest clinical need, and those identified as the highest priority in state statute (71.24 and 71.34). The statutory classifications of acutely mentally ill, severely emotionally disturbed and/or having a level of functioning at or below 50 identify the most serious mental disorders. Children who fall here are easily recognizable by schools, family members and others as having complex and serious problems. Especially with children, the sooner the intervention occurs, the more likely the potential for long-term successful outcomes. Untreated disorders can result in school failure, family conflict, out of home placement, involuntary detentions and hospitalizations. The average cost of outpatient care for this population is $1280/child/year. An involuntary treatment assessment alone costs about $1,675; involuntary detention in an E&T for 10 days runs $3,600; and an inpatient stay in a children's long-term inpatient treatment facility or the Child Study and Treatment Center costs $500/day.

Estimated Impact of Reduced or Eliminated Funding

With reduced or no access to outpatient treatment, this seriously ill population will become increasingly dependent on crisis services, and clinical symptoms and problems will deteriorate to the level of ITA referral and/or need for inpatient hospitalization. Utilization statistics indicate that individuals who receive only crisis services are far more likely to have a CDMHP investigation than those receiving outpatient services are. Without outpatient, treatment, long-term positive treatment outcomes are jeopardized, and there is increased risk of school failure/dropout, suicide, involvement in substance abuse and/or criminal activities, and family instability.

"Non-Medicaid" Community Mental Health Services

Activity #10: OUTPATIENT TREATMENT FOR NON-MEDICAID ADULTS CLASSIFIED AS ACUTELY OR CHRONICALLY MENTALLY ILL

Description: Individual and family counseling, case management, day treatment, medication management, and related services for non-Medicaid adults who are "acutely mentally ill" or "chronically mentally ill" according to statutory Priority Population standards; or who are having serious symptoms such as suicidal ideation, severe obsessional rituals, or inability to keep a job, as measured by an intake score of 50 or lower on the Global Assessment of Functioning scale.

See Appendix C for complete state "Priority Population" definitions, and Appendix E for global assessment indicators.

FY 03 Persons Served: 12,000 Non-Medicaid Adults

FY 03 Non-Medicaid Cost: $16.5 Million

Estimated Impact of Continued Funding

Outpatient services are an essential treatment and stabilizing component of adult community mental health services. Adults in this category represent those with the highest clinical need, the most serious disorders, the most limited functioning levels and the highest priority in state statute (71.05 and 71.24). The statutory classifications of acutely mentally ill, chronically mentally ill and/or having a level of functioning at or below 50 are tools for identifying the most disabled, vulnerable adults. These adults are easily recognizable in the community as having complex and serious mental health problems. The earlier that treatment intervention occurs, the more likely the potential for long-term successful outcomes, improved functioning and increased self-sufficiency. Untreated serous disorders can result in increased symptoms, decompensation and declining functioning, leading to involuntary detentions and hospitalizations. The average cost of outpatient care for this population is $1375/adult/year. An involuntary treatment assessment alone costs about $1,675; involuntary detention in an E&T for 10 days runs $3,600; and inpatient hospitalization in the state hospital costs $342/day.

Estimated Impact of Reduced or Eliminated Funding

With reduced or no access to outpatient treatment, this seriously ill population will become increasingly dependent on crisis services, and clinical symptoms and problems will deteriorate to the level of ITA referral and/or need for inpatient hospitalization. Utilization statistics indicate that individuals who receive only crisis services are far more likely to have a CDMHP investigation than those receiving outpatient services are. Long-term positive treatment outcomes are jeopardized, and there is increased risk of suicide, involvement in substance abuse and criminal activities, homelessness, and threats to community safety.

"Non-Medicaid" Community Mental Health Services

Activity #11: OUTPATIENT TREATMENT FOR NON-MEDICAID CHILDREN CLASSIFIED AS SERIOUSLY DISTURBED

Description: Individual and family counseling, case management, day treatment, medication management, consultation to teachers and other care-givers, and related services for non-Medicaid children who are "seriously disturbed" according to statutory Priority Population standards; or who are having sporadic functional difficulties or symptoms, as measured by an intake score of 60 or lower on the Children's Global Assessment Scale.

See Appendix C for complete state "Priority Population" definitions, and Appendix E for global assessment indicators.

FY 03 Persons Served: 1,050 Non-Medicaid Children

FY 03 Non-Medicaid Cost: $0.8 Million

Estimated Impact of Continued Funding

Outpatient services are the treatment and stabilizing components of children's mental health services. Children and youth in this category have serious clinical needs, and meet criteria as a state priority population (71.24 and 71.34). These are children whose mental disorder is clearly interfering with functioning and/or development and learning, and who experience difficulties in several, but not all social areas. Appropriate intervention can reduce symptoms, minimize disruption in personality development and learning, keep kids in school and dramatically increase the likelihood of successful life outcomes. Lack of treatment for this group can lead to more severe symptoms, school failure, family conflict, out of home placement, and in some cases, involuntary detentions and hospitalizations. The annual cost of providing outpatient care for this population is $762/child.

Estimated Impact of Reduced or Eliminated Funding

With reduced or no access to outpatient treatment, this population will become increasingly dependent on crisis services; clinical symptoms and problems will deteriorate, in some cases to the level of ITA referral and/or need for inpatient hospitalization. Utilization statistics indicate that individuals who receive only crisis services are far more likely to have a CDMHP investigation than those receiving outpatient services are. Without treatment, long-term positive outcomes are jeopardized, family and school problems increase, and there is greater risk for school failure and dropout, suicide, involvement in substance abuse and criminal activities, and family instability.

"Non-Medicaid" Community Mental Health Services

Activity #12: OUTPATIENT TREATMENT FOR NON-MEDICAID ADULTS CLASSIFIED AS SERIOUSLY MENTALLY ILL

Description: Individual and family counseling, case management, day treatment, medication management, and related services for non-Medicaid adults who are "seriously mentally ill" according to statutory Priority Population standards; or who are having at least moderate symptoms such as occasional panic attacks, flat affect and circumstantial speech, or conflicts with co-workers, as measured by an intake score of 51-60 on the Global Assessment of Functioning scale.

See Appendix C for complete state "Priority Population" definitions, and Appendix E for global assessment indicators.

FY 03 Persons Served: 4,400 Non-Medicaid Adults

FY 03 Non-Medicaid Cost: $3.2 Million

Estimated Impact of Continued Funding

Outpatient services are an essential treatment and stabilizing component of adult community mental health services. Adults in this category represent individuals with serious clinical needs, who may be gravely disabled, have prior history with the mental health system, and/or have disorders that cause major impairment in daily living. They meet the statutory classification of seriously disturbed person and/or have a functioning level between 51-60 on the Global Assessment of Functioning scale. These adults are recognizable in the community as having noticeable and serious mental health related problems. The earlier that treatment intervention occurs, the more likely the potential for long-term successful outcomes, improved functioning and increased self-sufficiency. Untreated serous disorders can result in increased symptoms, decompensation and decline in functioning, involuntary detentions and hospitalizations. The average cost of outpatient care for this population is $727/adult/year.

Estimated Impact of Reduced or Eliminated Funding

With reduced or no access to outpatient treatment, this disabled population will become increasingly dependent on crisis services; clinical symptoms and problems will deteriorate in some cases to the level of ITA referral and/or need for inpatient hospitalization. Utilization statistics indicate that individuals who receive only crisis services are far more likely to have a CDMHP investigation than those receiving outpatient services are. Long-term positive treatment outcomes are jeopardized, and there is increased risk of suicide, as well as involvement in substance abuse and criminal activities.

"Non-Medicaid" Community Mental Health Services

Activity #13: OUTPATIENT TREATMENT FOR ALL OTHER NON-MEDICAID CHILDREN

Description: Individual and family counseling, case management, day treatment, medication management, consultation to teachers and other care-givers, and related services for non-Medicaid children served in FY 03 who were not classified as meeting one of the statutory Priority Population standards; and whose intake score on the Children's Global Assessment Scale, if available, exceeded 60.

See Appendix C for complete state "Priority Population" definitions, and Appendix E for global assessment indicators.

FY 03 Persons Served: 1,700 Non-Medicaid Children

FY 03 Non-Medicaid Cost: $1.1 Million

Estimated Impact of Continued Funding

This category likely represents a mix of clinical groupings as well as some unclear/unknown groupings due to reporting and coding discrepancies and/or inadequacies. Possible groups include:

- Individuals on maintenance levels of care whose functioning has improved due to treatment and support but would deteriorate if discharged from treatment
- Individuals served with funding not limited to statutory priority populations, but reported through the state mental health information system
- Individuals ready for discharge
- Individuals with missing codes and/or incorrect codes due to human error in coding and reporting

Continued funding would allow for in-depth review of this population group, updated reporting/coding and determination of ongoing medical necessity for continued service or discharge planning. Elimination of services to this group may not result in desired savings depending on the reasons individuals are in this group. The average cost of serving this group has been $647/child/year.

Estimated Impact of Reduced or Eliminated Funding

May result in savings, depending on accuracy of clinical coding as a reflection of medical necessity. Elimination of funding (and termination of services) without better understanding the clinical nature of this group could cause hardship to individuals still meeting medical necessity criteria.

"Non-Medicaid" Community Mental Health Services

Activity #14: OUTPATIENT TREATMENT FOR ALL OTHER NON-MEDICAID ADULTS

Description: Individual and family counseling, case management, day treatment, medication management, and related services for non-Medicaid adults served in FY 03 who were not classified as meeting one of the state Priority Population definitions; and whose Global Assessment of Functioning intake score, if available, exceeded 60.

See Appendix C for complete state "Priority Population" definitions, and Appendix E for global assessment indicators.

FY 03 Persons Served: 5,400 Non-Medicaid Adults

FY 03 Non-Medicaid Cost: $3.0 Million

Estimated Impact of Continued Funding

This category likely represents a mix of clinical groupings as well as some unclear clinical population groups due to reporting and coding discrepancies and/or inadequacies, such as:

- Individuals on maintenance levels of care whose functioning has improved due to treatment and support but would deteriorate if discharged from treatment
- Individuals served with funding not limited to statutory priority populations, but reported through the state mental health information system
- Individuals ready for discharge
- Missing codes and human error in coding and reporting

Continued funding would allow for in-depth review of this population group, updated reporting/coding and determination of ongoing medical necessity for continued service or discharge planning. Elimination of services to this group may not result in desired savings depending on the reasons individuals are in this group. The average cost of serving this group has been $555/individual/year.

Estimated Impact of Reduced or Eliminated Funding

May result in savings, depending on accuracy of clinical coding as a reflection of medical necessity. Elimination of funding (and termination of services) without better understanding the clinical nature of this group could cause hardship to individuals still meeting medical necessity criteria.